

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966154</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br>R<br><b>04/15/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PALMS OF ST LUCIE WEST (THE)</b> |                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>501 NW CASHMERE BLVD.<br/>PORT SAINT LUCIE, FL 34986</b> |                                                                                                                          |  |                                                             |
| (X4) ID<br>PREFIX<br>TAG                                                | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                             | ID<br>PREFIX<br>TAG                                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                    |
| {A 000}                                                                 | Initial Comments<br><br>A revisit to the Change of Ownership was<br>conducted by desk review for Palms Of St Lucie<br>West (The). Previously cited deficiencies were<br>found to be corrected at the time of the survey. | {A 000}                                                                                              |                                                                                                                          |  |                                                             |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE